

Los Angeles Unified School District Preparticipation Physical Evaluation

Date of Exam: _____

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____
 Grade: _____ School: _____ Sport(s): _____
 Address: _____ Phone: _____
 Personal Physician/Provider: _____
 In case of emergency, contact: Name: _____ Relationship: _____
 Phone (H): _____ (W): _____ (Cell): _____

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

- Medicines Pollens Food Stinging insects

This section is to be carefully completed by the student and his/ her parent(s) or legal guardian(s) before participation in interscholastic athletics. Explain Yes answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in a hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> A Heart Infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol Other _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome?)			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendinitis that caused you to miss a practice or game?			44. Have you had any eye injuries?		
18. Have you had any broken or fractured bones or dislocated joints?			45. Do you wear glasses or contact lenses?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			46. Do you wear protective eyewear, such as goggles or a face shield?		
20. Have you ever had a stress fracture?			47. Do you worry about your weight?		
21. Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			48. Are you trying to or has anyone recommended that you gain or lose weight?		
22. Do you regularly use a brace, orthotics or other assistive device?			49. Are you on a special diet or do you avoid certain types of food?		
23. Do you have a bone, muscle or joint injury that bothers you?			50. Have you ever had an eating disorder?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			51. Do you have any concerns that you would like to discuss with a doctor?		
25. Do you have any history of juvenile arthritis or connective tissue disease?			FEMALES ONLY		
			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		
			Explain "yes" answers here:		

I hereby state, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete

Signature of parent/guardian

Date

Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

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Student's Name: _____ DOB: _____

Height: _____ Weight: _____ %BMI (optional): _____ Pulse: _____ BP _____ / _____, (_____ / _____, _____ / _____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

MEDICAL	Normal	Abnormal Findings
Appearance ● Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart ¹ ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only) ²		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ³		

MUSCULOSKELETAL

Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck walk, single leg hop		

¹ Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam

² Consider GU exam if in private setting. Having 3rd party present is recommended.

³ Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

Clearance

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____

Reason/Recommendations _____

I have evaluated the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) _____ (MD, DO, NP or PA) Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____